Report

Key Recommendations of High-Level Expert Group Report on Universal Health Coverage for India

The High-Level Expert Group (HLEG) on Universal Health Coverage (UHC) was constituted by the Planning Commission of India in October 2010, under the chairmanship of Prof. K. Srinath Reddy, with the mandate of developing a framework for providing easily accessible and affordable health care to all Indians which submitted its report in October, 2010. HLEG recognized that it is possible for India, even within the financial resources available to it, to devise an effective architecture of health financing and financial protection that can offer UHC to every citizen.

HLEG defined UHC for the purpose of report as follows:
"Ensuring equitable access for all Indian citizens, resident in any part of the country, regardless of income level, social status, gender, caste, or religion, to affordable, accountable, appropriate health services of assured quality (promotive, preventive, curative, and rehabilitative) as well as public health services addressing the wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services"

Health care services to all citizens covered under UHC will be made available through the public sector and contracted-in private facilities (including NGOs and nonprofits). The HLEG examined the range of services that could be offered by the institutions participating in the UHC program. Two different options emerged: In the first option, private providers opting for inclusion in the UHC system would have to ensure that at least 75% of outpatient care and 50% of in-patient services are offered to citizens under the national health package (NHP). For these services, they would be reimbursed at standard rates as per levels of services offered, and their activities would be appropriately regulated and monitored to ensure that services guaranteed under the NHP are delivered cashless with equity and quality. The second alternative entails that institutions participating in UHC would commit to provide only the cashless services related to the NHP and not provide any other services which would require private insurance coverage or out of pocket payment.

HLEG developed specific recommendations in six critical areas that are essential to augment and strengthen the capacity of India's health system to fulfill the vision of UHC. These are the Health Financing and Financial Protection, Health Service Norms, Human Resources for Health (HRH), Community Participation and Citizen Engagement, Access to Medicines, Vaccines and Technology, and Management and Institutional Reforms. Key recommendations on health financing and financial protection are that government (Central government and states combined) should increase public expenditures on health from the current level of 1.2% of GDP to at least 2.5% by the end of the 12th plan, and to at least 3% of GDP by 2022. It recommended use of general taxation as the principal source of health care financing – complemented by additional mandatory deductions for health care from salaried individuals and tax payers, either as a proportion of taxable income or as a proportion of salary. It recommended ensuring availability of free essential medicines by increasing public spending on drug procurement. It recommended that user fees of all forms be dropped as a source of government revenue for health. Independent agencies in the private sector and insurance companies under schemes such as the Rashtriya Swasthya Bima Yojana (RSBY) have been able to achieve expected enrolment, utilization levels, and fraud control. However, HLEG believe that for a number of reasons, this mechanism is not appropriate for the UHC system. The reason the HLEG sees RSBY and other government funded schemes as incomplete solutions is that they provide some coverage for hospitalised secondary or tertiary care but neglect primary care and outpatient care which are the major contributors to out of pocket expenditure.

HLEG put lot of emphasis on primary health care and recommended that expenditures on primary health care, including general health information and promotion, curative services at the primary level, screening for risk factors at the population level, and

cost-effective treatment, targeted toward specific risk factors, should account for at least 70% of all health care expenditures. It recommended developing a National Health Package that offers, as part of the entitlement of every citizen, essential health services at different levels of the health care delivery system with ensuring adherence to quality assurance as per Indian Public Health Standards (IPHS). It envisages that over time, every citizen will be issues an IT-enabled National Health Entitlement Card (NHET) that will ensure cashless transactions, allow for the mobility in the country, and contain personal health information.

Key requirement to ensure UHC is the provision of adequate human resources. It recommended adequate numbers of trained health care providers and technical health care workers at different levels by giving primacy to the provision of primary health care, increasing HRH density to achieve WHO norms of at least 23 health workers per 10,000 population (doctors, nurses, and midwives) and enhance the quality of HRH education and training by introducing competency-based, health system-connected curricula and continuous education. HLEG proposed setting up of District Health Knowledge Institutes (DHKIs) in districts with a population of more than 500,000 in order to enhance the quality of health workers' education and training. It strongly recommended and endorsed the setting up of the National Council for Human Resources in Health (NCHRH) to prescribe, monitor and promote standards of health professional education. It recognized that ensuring effective and affordable access to medicines, vaccines and appropriate technologies is critical for promoting health security. It recommended the enforcement of price controls and price regulation on essential and commonly prescribed drugs as well as revising and expanding the essential drug list.

In order to improve community participation, it recommended transforming existing Village Health Committees or Health and Sanitation Committees into participatory Health Councils. The Health Councils should organize annual Health Assemblies at different levels (district, state, and nation) to enable community review of health plans and their performance as well as record ground level experiences that call for corrective responses at the systemic level.

Under managerial reforms, it recommended to introduce All India and state level Public Health Service Cadres and a specialized state level Health Systems Management Cadre in order to give greater attention to public health and also strengthen the management of the UHC system. Among Institutional reforms, it recommended the establishment of the National Health Regulatory and Development Authority (NHRDA) with three key units. System Support unit (SSU) to be responsible for developing the legal, financial, and regulatory norms as well as the Management Information System (MIS) for the UHC system. The National Health and Medical Facilities Accreditation Unit (NHMFAU) should be responsible for the mandatory accreditation of all allopathic and AYUSH health care providers in both public and private sectors as well as for all health and medical facilities. The Health System Evaluation Unit (HSEU) should be responsible for independently evaluating the performance of both public and private health services at all levels – after establishing systems to get real-time data for performance monitoring of inputs, outputs, and outcomes. Focusing on health promotion, it recommended setting up of National Health Promotion and Protection Trust (NHPPT) to play a catalytic role in facilitating the promotion of better health culture amongst people, health providers and policy-makers. The Trust should be an autonomous entity at the national level with chapters in the states. Finally, it also recommended investing in health sciences research and innovation to inform policy, programmes, and to develop feasible solutions. Although report highlighted the need for urgent and concrete actions addressing social determinants of health to achieve and sustain UHC, however, ways to achieve the same have been left open and no mechanism is suggested. The HLEG's report provides a framework for designing the UHC system; however, the group is careful in recommending that delivery of UHC requires many implementation pathways to be identified and operational processes needs to be worked out. We hope that this issue and note will help to initiate discussion on key recommendations of HLEG on universal coverage at all relevant public health fora to take it forward and for effective implementations.

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